Referral form

JWCH INSTITUTE, INC. Health & Medical Services

S3: C-11
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Completed by MD / PA / NP only

RECUPERATIVE CARE PROGRAM
Provider Referral Form

(TO BE COMPLETED BY **REFERRING PROVIDER**)

The Recuperative Care Program provides transitional housing, meals, case management, nursing and primary medical care to homeless individuals with acute medical conditions that would benefit from a respite from the rigors of living on the streets. The patient must be stable for discharge **TO HOME.** We are not staffed to provide any bedside assistance. We ask that the physician responsible for the care of the patient complete this form. The application and supporting materials can be faxed to us at (323) 263-8348. Please feel free to call us with any questions. We can be reached at (323) 263-8840.

Patient's Name: _____ Patient's MR#: _____

DOB: _____ SSN: _____

MEDICAL REASON for referral (ACUTE, time limited condition): _____

_____

_____

Admit date/Intial evaluation: _____ Any surg procedures? _____
(Procedures)

Does patient require wound care (if so pls describe the wound, location, size) _____

_____

Wound care instructions: _____

Are there mental/behavioural, health/substance abuse issues? _____
How have these been addressed? Pls attach any consultant recommendations and scheduled follow-up.

_____

Any other medical problems (PMH etc.)? _____

Any special care requirements? (Special diets, infectious dz concerns, etc.): _____

Anticipated D/C date: _____ Arrangements for specialty follow-ups? _____
(Pt to call/To be mailed is not acceptable)

S3: C-11, click here to see communicable dz disclosure

PATIENT'S STATUS

	Y	N		Y	N	
Able to care for self:	☐	☐	Any communicable dz? (TB, MRSA, scabies etc.)	☐	☐	If yes, pls explain. Any tx?
Pt requires O_2?	☐	☐	Bowel & bladder continent?	☐	☐	
Ambulatory?	☐	☐	Assistive device?	☐	☐	Assistive device used (pls attach PT notes)
Indwelling catheter?	☐	☐	Require insulin?	☐	☐	
Can pt self admin. meds?	☐	☐	IV abx upon d/c?	☐	☐	If yes, which abx and length of Rx

ESTIMATED LENGTH of stay in Recup Program: ____ days ____ wks or ____ mos

(Signature of Referring Provider)	Provider PRINTED Name	Contact Number	Date

FOR INTERNAL USE ONLY — **FOR INTERNAL USE ONLY**

Pt in Case Track System? ☐ Y ☐ N _____ (Checked By) Red Dot: ☐ Y ☐ N

Approved for Recup Care ☐ Y ☐ N If no, reason: _____

Reviewed by: _____ (Provider Signature) _____